**MUST READ!!!!**

**Before typing any information save this file to desktop and open in Adobe Acrobat Reader (free). In order for the submit button below to work as well as save progress. You may type information in without saving the file, then print and either fax or bring in to the center.**

Little Champs ACADEMY

Tyler

Franksville, WI 53126

Phone 262-884-4226

Fax 262-884-4230

Email director@littlechampswi.com

Visit us at littlechampswi.com.....or like us on Facebook!!

☐ New ☐ Change

# Little Champs Academy
# Schedule Form

**Please note all billing changes effective in 2 weeks. All spaces must be completed, please write N/A if it does not apply**

Date:_____ Start Date / Billing Effective Date

Child Name _____ Date of Birth _____

Parent Name _____

Address _____

Home Phone _____ Cell _____ Work _____

E-mail address_____

## Schedule

I agree my child's schedule will be:

Program type (circle one): ☐ Infant ☐ 2yr ☐ 3-5yr ☐ 4K

☐ School Age (5 yr.+) School Attending: _____

I am eligible for a discount (circle one): ☐ Employee ☐ Multi-child ☐ Military ☐ Group

☐Other:_____

| | | | Transportation |
|---|---|---|---|
| ☐ Monday | from _____ | to _____ | am ☐ pm ☐ |
| ☐ Tuesday | from _____ | to _____ | am ☐ pm ☐ |
| ☐ Wednesday | from _____ | to _____ | am ☐ pm ☐ |
| ☐ Thursday | from _____ | o _____ | am ☐ pm ☐ |
| ☐ Friday | from _____ | to _____ | am ☐ pm ☐ |
| ☐ Saturday | from _____ | to _____ | NA NA |

| Tuition Rate Per Week | Transportation Rate Per Week |
|---|---|
| | |
| | |

**Total:**

Family Total

1._____
2._____
3._____
4._____
Total _____

Schedule description:_____

## Payment

I agree my weekly tuition will be paid in advance as follows:

☐ Monthly (ACH, Credit Card, Check/Cash) ☐Weekly (Check/Cash)

☐ Credit Card information: ☐ MasterCard ☐ Visa ☐ American Express

Name on Card: _____

Credit Card #: _____ Expiration Date: _____

Zip Code: _____ 3 digit code #: _____

☐ I have read and understand the current tuition scale and terms of payment and agree to the charges listed.
☐ I understand that I am responsible for the weekly tuition whether or not my child is in attendance.

Parent Signature: _____ Date: _____

Staff Signature: _____ Date: _____

# Little Champs Academy
# Account Guarantee

Little Champs Academy requires tuition be paid prior to services rendered.

- I understand that I must pay tuition charges in advance of services.
- I am eligible for state assistance with my childcare: ☐ YES ☐ NO.
- I understand that if I am eligible for state assistance that I have two weeks from my child's start date or authorization end date to obtain my new authorization or I will be responsible for all tuition charges.
- I understand that if I am on state assistance and my authorization comes through that I will be reimbursed any money owed to me minus copays once the center receives payment.
- I have read the current tuition scale and understand and agree to the charges listed.
- I understand that if my tuition is late that my credit card or checking account will be debited the amount due.
- I understand that if my payment does not clear services will be interrupted until payment is received.
- I guarantee my account with:
    - ☐ Credit Card
    - ☐ Direct withdrawal from my checking or saving (ACH)
- My credit card information is:
    - Credit Card #: _____
    - Expiration Date: _____
    - Name on Card: _____
    - Zip Code: _____
    - 3 digit pin: _____
    - Credit Card Type: ☐ MasterCard ☐ Visa ☐ American Express
- My personal bank account information: ( please attach a voided check)
    - Bank Routing Number: _____
    - Bank Account Number: _____
    - Type: ☐ Checking ☐ Savings

Child Name: _____

Parent Name: _____

Parent Signature: _____ Date: _____

# Health History and Emergency Care Plan

**Use of form:** This form is voluntary and meets the requirements in DCF 250.04(6)(a)1., DCF 251.04(6)(a)6., and DCF 252.41(4)(a)6. of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** The parent / guardian may complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

**CHILD INFORMATION**

| Name (Last, First, MI) | Birthdate (mm/dd/yyyy) | First Day of Attendance (mm/dd/yyyy) |
|---|---|---|
| | | |

Home Address (Street, City, State, Zip Code)

**PARENT / GUARDIAN INFORMATION** Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

| Name | Primary Telephone Number | Work Telephone Number | Secondary Telephone Number |
|---|---|---|---|
| | | | |
| Name | Primary Telephone Number | Work Telephone Number | Secondary Telephone Number |
| | | | |

**PHYSICIAN / MEDICAL FACILITY INFORMATION**

| Physician Name | Medical Facility Address | Telephone Number |
|---|---|---|
| | | |

**SUNSCREEN / INSECT REPELLENT AUTHORIZATION** If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 250.07(6)(h)6., Authorizations shall be reviewed periodically and updated as necessary. Per DCF 251.07(6)(g)3., authorizations shall be reviewed every 6 months and updated as necessary.

| | Brand Name | Ingredient Strength |
|---|---|---|
| ☐ Yes ☐ No I authorize the center to apply sunscreen to my child.<br>☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen. | | |
| ☐ Yes ☐ No I authorize the center to apply repellent to my child.<br>☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent. | Brand Name | Ingredient Strength |

**HEALTH HISTORY AND EMERGENCY CARE PLAN** If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.
   - ☐ No specific medical condition
   - ☐ Any disorder, including Cognitively Disabled, LD, ADD, ADHD, or Autism
   - ☐ Asthma
   - ☐ Cerebral palsy / motor disorder
   - ☐ Diabetes
   - ☐ Epilepsy / seizure disorder
   - ☐ Gastrointestinal or feeding concerns, including special diet and supplements

☐ Other condition(s) requiring special care – Specify.

☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
☐ Food allergies – Specify food(s).

☐ Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication – Child Care Centers* should be attached to this form. Note: Group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.
   a.
   b.
   c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

**SIGNATURE** – Parent or Guardian | Date Signed (mm/dd/yyyy)

**Review dates:** _____ _____ _____ _____ _____

**DEPARTMENT OF CHILDREN AND FAMILIES**
Division of Early Care and Education

http://dcf.wisconsin.gov

# CHILD CARE ENROLLMENT

**Use of form:** Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(6)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

**CHILD INFORMATION**

| Name (Last, First, MI) | Birthdate (mm/dd/yyyy) | First Day of Attendance |
|---|---|---|
| | | |

**PARENT OR GUARDIAN** – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the department recommends the provider obtain and attach a schedule.

| a. Name and Relationship to Child | Home / Cell Phone No. | Email Address Where Reachable While Child is in Care |
|---|---|---|
| | | |

| Home Address (Street, City, State, Zip) | Does child reside at this location? ☐ Yes ☐ No | Place of Employment and Work Phone No. |
|---|---|---|
| | | |

| b. Name and Relationship to Child | Home / Cell Phone No. | Email Address Where Reachable While Child is in Care |
|---|---|---|
| | | |

| Home Address (Street, City, State, Zip) | Does child reside at this location? ☐ Yes ☐ No | Place of Employment and Work Phone No. |
|---|---|---|
| | | |

**AUTHORIZED PERSONS** – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off. If no one, write "None."

| a. Name and Relationship to Child | Home / Cell Phone No. | Email Address Where Reachable While Child is in Care | Place of Employment and Work Phone No. |
|---|---|---|---|
| | | | |
| b. Name and Relationship to Child | Home / Cell Phone No. | Email Address Where Reachable While Child is in Care | Place of Employment and Work Phone No. |
| | | | |

**EMERGENCY CONTACT** – The person to be notified in an emergency when parents / guardians cannot be reached.
☐ Yes ☐ No This person is authorized to pick up the child.

| Name and Relationship to Child | Home / Cell Phone No. | Email Address Where Reachable While Child is in Care | Place of Employment and Work Phone No. |
|---|---|---|---|
| | | | |

**PHYSICIAN OR MEDICAL FACILITY**

| Name | Address (Street, City, State, Zip Code) | Telephone Number |
|---|---|---|
| | | |

**AUTHORIZATIONS**

☐ Yes ☐ No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
☐ Yes ☐ No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.
☐ Yes ☐ No I give permission for my child to participate in ☐ Transported ☐ Walking field trips and other activities during operating hours.
☐ Yes ☐ No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

| **SIGNATURE** – Parent or Guardian | Date Signed |
|---|---|
| | |

**DEPARTMENT OF CHILDREN AND FAMILIES**
Division of Early Care and Education

dcf.wisconsin.gov/

# CHILD HEALTH REPORT – CHILD CARE CENTERS

**Use of form:** Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.07(6)(L)3., and DCF 251.07(6)(k)3. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Except for a school-aged child, each child 2 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant or HealthCheck provider to be completed, signed and dated. The licensee shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian were to include a copy of the child's immunization record when submitting this form to the child care center.

## PARENT OR GUARDIAN – Complete this section.

| Name – Child (Last, First, MI) | Birthdate – Child (mm/dd/yyyy) |
|---|---|
| | |

Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

Address – Parent or Guardian (Street, City, State, Zip Code)

## HEALTH PROFESSIONAL – Complete this section.

Instructions for feeding and care of child with special problems, including allergies – Specify (attach information as necessary).

☐ Yes ☐ No Does the child have a milk allergy? If "Yes", identify the recommended milk substitute.

Date of most recent blood lead test: _____ (mm/dd/yyyy). Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

## AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

| Name – MD, PA or HealthCheck Provider (type or print) | Address (Street, City, State, Zip Code) |
|---|---|
| | |

| **SIGNATURE** – MD, PA or HealthCheck Provider | Date of Examination |
|---|---|
| | |

**DEPARTMENT OF HEALTH SERVICES**
Division of Public Health
F-44192 (Rev. 09/08)

**STATE OF WISCONSIN**
ss. 252.04,Wis. Stats.

# DAY CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO DAY CARE CENTER . State law requires all children in day care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the day care center.** These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the day care center. See "Waivers" below. If you have any questions on immunizations or how to complete this form, please contact your child's day care provider or your local health department.

## PERSONAL DATA — PLEASE PRINT

**STEP 1**

| Child's Name(Last, First, Middle Initial) | Date of Birth (Month/Day/Year) | Area Code/Telephone Number |
|---|---|---|
| Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial) | Address (Street, Apartment number, City, State, Zip) | |

## IMMUNIZATION HISTORY

**STEP 2**

List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (4) OR (**X**) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

| TYPE OF VACCINE | First Dose Month/Day/Year | Second Dose Month/Day/Year | Third Dose Month/Day/Year | Fourth Dose Month/Day/Year | Fifth Dose Month/Day/Year |
|---|---|---|---|---|---|
| Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT) | | | | | |
| Polio | | | | | |
| Hib (Haemophilus *Influenzae* Type B) | | | | | |
| Pneumococcal Conjugate Vaccine (PCV) | | | | | |
| Hepatitis B | | | | | |
| Measles-Mumps-Rubella (MMR) | | | | | |
| Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease. | | | | | |

**Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.**

☐ Yes year _____ (Vaccine is not required)

☐ No or Unsure (Vaccine is required)

## REQUIREMENTS

**STEP 3**

The following are the minimum **required** immunizations for the child's age/grade at entry. All children within the range must meet these requirements at day care entrance. Children who reach a new age/grade level while attending this day care must have their records updated with dates of additional required doses.

| AGE LEVELS | NUMBER OF DOSES | | | | | | |
|---|---|---|---|---|---|---|---|
| 5 months through 15 months | 2 DTP/DTaP/DT | 2 Polio | 2 Hib | 2 PCV | 2 Hep B | | |
| 16 months through 23 months | 3 DTP/DTaP/DT | 2 Polio | 3 Hib[1] | 3 PCV[2] | 2 Hep B | 1 MMR[3] | |
| 2 years through 4 years | 4 DTP/DTaP/DT | 3 Polio | 3 Hib[1] | 3 PCV[2] | 3 Hep B | 1 MMR[3] | 1 Varicella |
| At Kindergarten entrance | 4 DTP/DTaP/DT[4] | 4 Polio | | | 3 Hep B | 2 MMR[3] | 2 Varicella |

[1]If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

[2]If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

[3]MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

[4]Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

## COMPLIANCE DATA AND WAIVERS

**STEP 4**

**IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the day care center), OR**

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to day care center).

☐ Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the day care center in writing as each dose is received.

**NOTE: Failure to stay on schedule or report immunizations to the day care center may result in court action against the parents and a fine of up to $25.00 per day of violation.**

☐ For health reasons this child should not receive the following immunizations _____(List in STEP 2 any immunizations already received)

_____
Physician's Signature Required

☐ For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

☐ For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

## SIGNATURE

**STEP 5**

To the best of my knowledge this form is complete and accurate.

_____ _____

SIGNATURE - Parent, Guardian or Legal Custodian — Date Signed

Dear Parents,

Access the Parent Handbook on our website, www.littlechampswi.com. Please read it and return this form stating that you have read and understand everything contained herein. Please feel free to ask the director or the staff questions about any of the topics this book addresses, or clarification of any policy addressed herein. Please remember that these policies are a general guideline only, and are subject to change without notice. The handbook available in the hallway of the center is our updated version at this time. We are working on updating the website.

Thank you,

Little Champs Academy Staff

I have received and read the Parent Handbook, and understand the policies discussed herein.

_____ _____

Parent or guardian signature Date

# MEDIA/PHOTOGRAPHY CONSENT AND RELEASE FORM

From time to time Little Champs Academy uses pictures of our students in newsletters and for marketing purposes. If you do not wish your child's photo to be used for these purposes please indicate below.

As the parent of a child/children Little Champs Academy, I agree to the following:

- I understand that my child(ren) whose name(s) are listed below may be photographed at Little Champs Academy during normal daycare hours, field trips, or activities.

- I understand and give my permission that these photographs may be used in school newsletters or mounted on the Little Champs Academy website or Facebook page

- I give permission for my child to be videotaped and/or photographed for educational or training purposes. Being able to videotape or photograph will allow us to analyze behaviors and teaching techniques and monitor progress as well as use them for training workshops we periodically perform for professionals.

The following are the names of my children attending Little Champs Academy:

Please print your child full name:

_____

_____

☐ Yes, I confirm that I have read and understood the above, and agree to have my child photos mounted on Little Champs Academy website, Facebook page or newsletters.

☐ No, I do not wish to have my child photographed.

_____ _____

Name (please print) Signature

_____

Date

Helping
Communities
Help Children

# Is Your Child Well Enough to Attend Daycare?

## Health Information

It is not always easy to decide if your child is sick enough to stay home or well enough to be in day-care. Children who come to daycare are expected, with few exceptions, to participate fully in daycare activities.

Here are some guidelines for parents and providers to help in decision-making regarding keeping a child home or sending a child home:

### Parents: Keeping a Child Home

1) **Fever:** A fever of 100° or more signals an illness that is probably going to make a child uncomfortable and unable to function well in a daycare setting. Your child should stay home until he/she is feeling better.
2) **Vomiting, Diarrhea or Severe Nausea:** These are symptoms that require a child to remain at home until a normal diet is tolerated the night before and the next morning.
3) **Infectious Diseases:** Diseases such as impetigo, pink eye with thick drainage, and strep throat require a doctor's examination and prescription for medication. Children may not return to daycare until a doctor has been contacted, medication has been started and the child is feeling better. ***Children with chicken pox may return to daycare when all the scabs are completely dried and no lesions are developing (usually 5-7 days).***
4) **Rashes:** Rashes or patches of broken, itchy skin need to be examined by a doctor if they appear to be spreading or not improving.
5) **Injuries:** If a child has an injury that causes continuous discomfort, the child should not attend daycare until a doctor checks the condition or it improves.

### Providers: Removal of A Child From Daycare

1) **Fever:** Fever is defined as having a temperature of 100° F or higher taken under the arm, 101° F if taken orally, or 102° F taken rectally. For children 4 months or younger, the lower rectal temperature of 101° is considered a fever threshold.
2) **Diarrhea:** runny, watery, or bloody stools.
3) **Vomiting:** 2 or more times in a 24-hour period.
4) **Body Rash with Fever or Sore Throat with fever and swollen glands.**
5) **Severe Coughing:** child gets red or blue in the face or makes high-pitched whooping sound after coughing.
6) **Eye Discharge:** thick mucus or puss draining from the eye, or pink eye.
7) **Yellowish skin or eyes.**
8) **Child is irritable, continuously crying, or requires more attention than you can provide without compromising the health and safety of other children in your care.**

# Items to Bring For Your Child At Little Champs Academy

**If your child is 6 weeks to 2 years old**

Diapers
Wipes
Diaper rash ointment
Formula / breast milk
2 Bottles per child
Solid foods / lunch
At least 2 extra outfits
Pacifier if used
A favorite blanket or small pillow if needed for napping
Appropriate outdoor clothing for the season
Sunscreen/insect Repellent
Swim diaper/suit/towel in summer

**If your child is 2 years and older**

Daily lunch
Diapers or pull ups if not potty trained
Wipes if not potty trained
At least one change of clothes
Blanket or small pillow if needed for napping
Appropriate outdoor clothing for the season
Sunscreen/insect repellent- with authorization form
Swim suit /towel in summer

- Please be sure to label all items you bring. We are not liable for missing items. Please be sure to LABEL ☺

**DEPARTMENT OF CHILDREN AND FAMILIES**
Division of Early Care and Education



# TRANSPORTATION PERMISSION – CHILD CARE CENTERS

**Use of form:** Use of this form is voluntary. However, completion of this form will help ensure compliance with portions of DCF 202.08(9), DCF 250.08, DCF 251.08 and DCF 252.09 of the Wisconsin Administrative Codes regarding regularly scheduled, operator / center-provided / center-contracted transportation of children in care. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** The parent / guardian should complete this form for placement in the child's file at the center and update the information as needed. The center shall maintain the completed form in the child's file for the duration of the child's enrollment. Note: A copy of this form shall be carried in the vehicle when transporting the child. If the child has special health care needs, also include a copy of DCF-F-CFS-2345, *Health History and Emergency Care Plan* or the center's equivalent form.

## A. CHILD INFORMATION

| Name | Home Address (Street, City, State, Zip Code) |
|---|---|
| | |

☐ Yes ☐ No Does the child have any special health care needs? If "Yes", attach the department form, *Health History and Emergency Care Plan,* or the center's equivalent form.

## B. PARENT / GUARDIAN INFORMATION Provide information where the parent / guardian may be reached while the child is in care.

| 1. Name | Home Telephone Number | Work Telephone Number | Cellular Telephone Number |
|---|---|---|---|
| | | | |

| 1. Name | Home Telephone Number | Work Telephone Number | Cellular Telephone Number |
|---|---|---|---|
| Address (Street, City, State, Zip Code) | | | |

| 2. Name | Home Telephone Number | Work Telephone Number | Cellular Telephone Number |
|---|---|---|---|
| Address (Street, City, State, Zip Code) | | | |

## C. EMERGENCY CONTACT INFORMATION Provide information on the person to contact if the parent / guardian cannot be reached.

| Name | Address (Street, City, State, Zip) | Telephone Number |
|---|---|---|
| | | |

## D. AUTHORIZED DESTINATIONS / PERSONS INFORMATION

| | Address Child Transported From (Street, City) | Address Child Transported To (Street, City) | Length of trip one way | Person Authorized to Receive Child |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |

Procedure to follow when parent / guardian or authorized adult is not at destination to receive child – Specify.

**E. CHILD'S HEALTH CARE PROVIDER INFORMATION**

| Name – Physician | Telephone Number |
|---|---|
| | |

Address (Street, City, State, Zip Code)

**F. AUTHORIZATION**

1. ☐ Yes ☐ No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
2. ☐ Yes ☐ No I hereby give permission for my school-aged child to enter a building unescorted.

| **SIGNATURE** – Parent / Guardian | Date Signed |
|---|---|
| | |